State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Enclosed is the Medi-Cal provider enrollment application package you requested. Requests for additional application packages should be directed to EDS, the Medi-Cal fiscal intermediary, at 1-800-541-5555.

PLEASE NOTE: New regulations (effective February 2003) governing the enrollment of providers in the Medi-Cal program now require additional information to be submitted with the application package. Applications will be reviewed to ensure that applicants and providers meet the new criteria, including the verification of insurance.

Instructions for completion of these documents are included on the forms. Please read the instructions carefully. If after reading the instructions you have questions regarding the completion of the application, disclosure statement and/or provider agreement, you may call the Provider Enrollment Branch at (916) 323-1945 between the hours of 8 a.m. and 5 p.m. to leave a message. Each applicant is sent written notice when the application package is received. Due to the volume of applications received, program staff is unable to reply to a request for the status of applications in process. Therefore, please allow for the 120 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Application packages that are incomplete or are submitted on a form other than the current Department of Health Services (DHS)-issued forms will be returned to you.

It is your responsibility to report to DHS any changes to information previously reported on the enrollment documents within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Application*. You may request a *Medi-Cal Supplemental Application* by contacting EDS.

For more information on the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click on "Publications," then "Provider Enrollment."

If you have any questions, please the call Provider Enrollment Branch at (916) 323-1945.

Provider Enrollment Branch
Payment Systems Division

Enclosures

(Revised 2/03)

MEDI-CAL PROVIDER GROUP APPLICATION

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

FOR STATE USE ONLY

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check one)

Date

❒ New provider group
(Separate applications are also required for each rendering provider in the provider group.)

❒ Additional business address for an existing provider group. Current provider group provider number(s): _____
(Separate applications are also required for each rendering provider in the provider group.) See Regulations, Section 51000.30(g) for exception.

❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, California Code of Regulations, Section 51000.55.)—Current Medi-Cal provider number: _____
(Separate applications are also required for each rendering provider in the provider group.)

Type of entity

❒ Sole proprietor ❒ Corporation: ❒ Limited liability corporation: ❒ Other: _____

❒ Partnership Corporate number: _____ Corporate number: _____

❒ Government State incorporated: _____ State incorporated: _____

1. Legal provider group name (as listed with the IRS)

2. Is this a fictitious business name? ❒ Yes ❒ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date	3. Provider group telephone number ( )
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)		

4. Provider group business address (number, street)	City	County	State	Nine-digit ZIP code
5. "Pay to" address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code
6. Mailing address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code

7. Federal Employer Identification Number (FEIN) or social security number (Attach a legible copy of the IRS form.)	8. Medicare billing number	9. Seller's Permit number (attach a legible copy)
___ ___ – ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___ – ___ ___ ___ ___		

10. Type of provider group	11. If physician(s), list specialty(ies)

12. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy)	13. State Laboratory License/Registration number (attach a legible copy)

14. List all providers rendering in the provider group (use additional sheets, if necessary)

Name	License Number	Social Security Number	Date of Birth

15. SELF CERTIFICATION AND STATEMENT OF INTENT TO EMPLOY A SEPARATE BILLING METHOD FOR HOSPITAL/CLINIC BASED PROVIDER GROUPS. (TO BE COMPLETED ONLY IF THE PRACTICE LOCATION IS A LICENSED FACILITY.)

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The undersigned hospital/clinic and provider group agree to the following requirements for the issuance of a Medi-Cal provider number to the hospital/clinic based group. It is agreed and understood by _____ and
(Provider group name)

_____
(Hospital/clinic name)

that there shall be no duplicate billing for inpatient services rendered to Medi-Cal beneficiaries. All billing for inpatient services provided by the group to Medi-Cal beneficiaries shall be billed using the provider group number. To ensure the money paid to the group is not included in the cost settlement process, we recommend that the hospital/clinic set up a separate nonreimbursable cost center to account for all clinic-related payments. Additionally, the hospital/clinic should keep track of overhead support costs related to the reimbursable costs. At year-end the costs related to the guarantee to group clinical billings should be easily identifiable by our audits staff on your cost report. If it appears impossible/impractical for you to set up a separate cost center, then the direct cost related to the group's clinical activities at a minimum should be eliminated from the trial balance cost via an A-8 adjustment on your cost report. This method of billing will become effective for services performed on or after _____. We declare under penalty of perjury
(Date)

under the laws of the State of California that the foregoing information is true and correct to the best of our knowledge.

Hospital/clinic name			
Address (number, street)	City	State	ZIP code
Print name of authorized hospital/clinic representative	Authorized hospital/clinic representative signature		Date
Print provider group name	Print name of authorized provider group representative		
Authorized provider group representative signature			Date

Information About Individual Signing This Application

16. Printed name of individual signing this application (last) (first) (middle)		17. Gender ❒ Male ❒ Female
18. Driver's license or state-issued ID number and state of issuance (attach a legible copy)	19. Date of birth	20. Social security number (***Optional***—see Privacy Statement below.) ____ ____ ____ — ____ ____ — ____ ____ ____ ____

21. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of the person authorized to bind the applicant or provider	Title

Executed at: _____, _____ on _____
(City) (State) (Date)

22. Notary Public—Please see instructions under number 22 for who must notarize.

Privacy Statement
(Civil Code, Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

INSTRUCTIONS FOR COMPLETION OF PROVIDER GROUP APPLICATION

DO NOT USE correction tape, white out, etc.; highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers may also need to provide additional information and documentation. Applicants may be subject to an onsite inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application, the attached disclosure statement and a provider agreement must also be completed for enrollment or continued enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enrollment action requested (check one); enter the date you are completing the application.

"New provider group" means the provider group is not currently enrolled with the Medi-Cal program and would like to have a Medi-Cal provider number issued.

"Additional business address for an existing provider group" means the provider group is currently enrolled in the Medi-Cal program and would like to add an additional business address, thus requesting a Medi-Cal provider number for that location. Please enter the existing provider group number. The rendering providers at the additional business address must submit separate Medi-Cal applications (appropriate to their provider type), disclosure statement and provider agreement. (See Regulations, Section 51000.30(g) for exception.)

"Continued provider group enrollment" means the provider group is currently enrolled in the Medi-Cal program and would like to continue participation. Enter the provider group number. The rendering providers in the provider group must submit separate Medi-Cal applications (appropriate to their provider type), disclosure statements, and provider agreements as well. (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Regulations, Section 51000.55.)

"Type of Entity": Check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. "Legal provider group name" means the legal business name listed with the Internal Revenue Service (IRS).
2. If this is a Fictitious Business Name, provide the Fictitious Business Statement or Fictitious Name Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement or Fictitious Name Permit to the application. Physician provider groups are to submit a legible copy of the Fictitious Name Permit issued by the Medical Board of California.
3. "Provider group telephone number" means the primary business telephone number used at the business address. A beeper number, answering service, pager, facsimile machine, biller or billing service phone, or answering machine shall not be used as the primary business telephone.
4. "Provider group address" means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
5. "Pay to address" means the address to which payment will be mailed. The "pay to address" should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. "Mailing address" is where the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the provider group or provider group applicant. Attach a legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363.
8. Insert the Medicare Billing number.
9. Insert the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
10. Indicate the type of provider group (e.g. Audiologists, Certified Nurse Midwives, Chiropractors, Occupational Therapists, Optometrists, Orthotists, Orthotists and Prosthetists, Nurse Anesthetists, Nurse Practitioners, Physicians, Physical Therapists, Podiatrists, Prosthetists, Psychologists, Respiratory Therapists, Speech Therapists).
11. If this is a physician provider group, list the specialty(ies) (i.e., Acupuncture, Allergy, Anesthesiology, Aviation, Cardiovascular Disease, Clinic/Mixed Specialty, Dermatology, Emergency Medicine, Endocrinology, Family Practice, Gastroenterology, General Practice/Medicine, General Surgery, Geriatrics, Gynecology, Hand Surgery, Hematology, Oncology, Infectious Disease, Internal Medicine, Manipulative Therapy, Neoplastic Diseases, Nephrology, Neurological Surgery, Neurology, Neurology [child], Nuclear Medicine, Obstetrics, Obstetrics/Gynecology Neonatal, Ophthalmology, Otolaryngology, Orthopedic Surgery, Otology, Laryngology, Rhinology, Pathology, Pathologic Anatomy, Clinical Pathology, Pathology [Forensic], Pediatric Allergy, Pediatric Cardiology, Pediatrics, Peripheral Vascular Disease, Pharmacology, Physical Medicine and Rehabilitation, Plastic Surgery, Proctology, Psychiatry, Psychiatry [child], Psychiatry Neurology, Public Health, Pulmonary Disease, Radiation Therapy, Radiology, Rheumatology, Roentgenology, Surgery [head and neck], Surgery [pediatric], Surgery [traumatic], Thoracic Surgery, Urology, Urologic Surgery). If this is not a physician provider group, write "N/A" on the line.
12. Enter the Clinical Laboratory Improvement Amendment (CLIA) Certificate number. Attach a legible copy of the CLIA Certificate.

13. Provide the State Laboratory License/Registration number. If this does not apply to you, enter "N/A." Attach a legible copy of the license/registration.

14. List the name, license number, social security number and date of birth of all rendering providers in the provider group. Attach additional sheets, if necessary. An individual application, disclosure statement, and provider agreement are required for each rendering provider in the provider group. The provider agreement is not required for physicians applying for enrollment as a rendering provider in a provider group. Provision of the social security number is optional (see Privacy Statement on page 2).

15. If you are providing services in a hospital or clinic (facility), please complete this certification.

16. "Printed name of the individual signing the application." Enter the last, first, and middle name of an individual acting on behalf of the group and with the authority to legally bind the applicant or provider as the sole proprietor, partner, corporate officer or government official when applying to the Department of Health Services for enrollment or continued enrollment as a provider in the Medi-Cal program.

17. Check (✓) the gender of the individual named in number 16.

18. Provide the driver's license or state-issued identification card number and state of issuance of the individual named in number 16. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.

19. Enter the date of birth of the individual named in number 16.

20. Provide the social security number of the individual named in number 16. Provision of the social security number is optional (see Privacy Statement on page 2).

21. An original signature of the individual named in number 16 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

22. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act DO NOT have to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ FEIN verification
- ❒ Seller's Permit
- ❒ Fictitious Business Name Statement or Fictitious Name Permit
- ❒ Signed Disclosure Statement
- ❒ Signed Provider Agreement
- ❒ Applications for all rendering providers in the provider group
- ❒ Applicable certifications
- ❒ Driver's license or state-issued identification card of individual signing the application